Student Name_____   **Clinical Education Center**_____

Semester (check one):   1_____   2_____   3_____   4_____   5_____   6_____

Date	Patient ID	Name of Exam/Procedure	Rm. or equip #	Fluoro: Exam Time	*O A P	REPEATS # & reason	Supervising RT (PRINT PLEASE)	Signature of RT (CRT/permit # for fluoro)

*O=Observe / A=Assist / P=Perform